COVID-19 SCREENING DECLARATION FOR GROUPS

Date: .....

I, the undersigned, hereby confirm that:

1. I have familiarised myself with the provisions of the organisation's workplace plan, policies and procedures regarding COVID-19.

2. I have not experienced any of the following symptoms in the past 14 days:
   - Fever in excess of 37.3 degrees
   - Cough
   - Sore throat
   - Redness of eyes
   - Shortness of breath (or difficulty in breathing).

3. I do not suffer from any of the following additional symptoms:
   - Body aches
   - Loss of smell or loss of taste
   - Nausea
   - Vomiting
   - Diarrhoea
   - Unusual fatigue
   - Weakness or tiredness.

4. I have not been in contact with other persons, that I am aware of, that suffered/suffer from the symptoms noted in paragraphs 2 and 3 above.

5. I undertake to immediately inform the Employer if I or any of my co-workers experience any of the symptoms in sub-clauses 2 and 3 while at work.

Name	Signature	Cell no.	Temp.	Time in	Time out

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